# Annotation: Insulating Public Health from Extremist Politics—Do We Need Boards of Health?

The report by McQuillan et al., "Risk Behavior and Correlates of Risk for HIV Infection in The Dallas County Household HIV Survey,"[1] in this issue re minds us of a sad chapter in public health history. It describes a pilot survey designed to determine the prevalence of human immunodeficiency virus-type 1 (HIV-1) and hepatitis B virus infection in the United States. In the last paragraphs, the authors state matter-of-factly how experts, concerned about possible bias associated with nonparticipation, recommended against national expansion of the survey.

At that time, such logic made sense. National HIV prevalence surveys were among the many acquired immunodeficiency syndrome (AIDS) issues caught up, not by the scientific qualms of experts, but in the political maelstrom of extremism. With the lack of national leadership from government, the right and fundamentalist religious groups entered into decision-making processes that should have been based on scientific reasoning but instead became centered on religious dogma. In retrospect, the conflict between public health and religious groups is not surprising, given the nature of HIV transmission. What is surprising is that national leaders allowed the conflict to prosper and, in some cases, dominate decision making over public health policy.

The opportunity for chaos arose early in the Reagan administration as the government refused urgings by the Centers for Disease Control and Prevention (CDC) to act rapidly to deal with the emerging disease now known as AIDS. That administration chose not to act, leaving the CDC with neither the resources nor the influence required to exert national leadership. Likewise, state and local health departments, weakened by cuts in federal resources that undermined the traditional structure of public health, were unable to take up the slack left by the CDC.

Into this vacuum of public health leadership entered those associated with conservative religious groups, whose interest was to stem sin rather than disease. Under their influence, which was exercised especially through the Domestic Policy Council, President Reagan called for

> a comprehensive program to determine the nationwide incidence of the human immunodeficiency virus and to predict its future occurrence and to initiate epidemiologic studies to determine the extent to which HIV has penetrated the various segments of our society.

Such a call, coming as it did from an administration that at once ignored the epidemic and claimed it was the will of God, did not have the ring of reason.

The CDC realized that in this atmosphere a probability sample of the United States would be unlikely to yield unbiased responses; at the same time, it was confident that reasonable estimates of HIV prevalence could be made by combining a variety of less expensive samples. Nonetheless, the CDC was forced by the president's call to attempt a survey. The scientific concern at the time was that nonparticipation of individuals at high risk of HIV infection would bias the results. Infection was infrequent in the population as a whole but common in specific groups having self-identifiable risk. In such a situation, selective nonparticipation of at-risk individuals could severely compromise the results of the survey.

Despite the best intentions and expertise of the researchers conducting the survey, the suspicions of those at risk did indeed compromise the results. In summarizing the difficulties of the survey, the investigators stated:

> When the [target] group is composed of HIV-infected people in 1988 in the United States—when the effects of discrimination and persecution have been bolstered by the idea of quarantining HIV-positive people emanating from the highest halls of government—the purest of scientific motives may, and probably should, be questioned.[2]

Unfortunately, with the United States being almost the sole source of information on AIDS early on in the epidemic, much of the world turned to the United States and especially to the CDC for guidance in dealing with the disease. Fortunately, some saw the constraints to which the CDC was subjected and ventured out on their own. Amsterdam led the way with needle exchange programs, as did Switzerland with national education and condom promotion campaigns. San Francisco led the way with norm-changing programs targeted toward gay and bisexual men, and Liverpool took the lead with liberalized drug treatment. Ultimately, it was these places that set the standards by which we measure today's HIV prevention programs.

More logical policy has emerged since the election of President Clinton. Thus, recent CDC publications have stressed the efficacy of condoms and needle exchange. To many working in the field of AIDS prevention, these articles must seem dated. But as the Reagan vacuum recedes into the past, their importance may lie less in their science than in their indication of significant change in policy.

That is good. We can now look forward to a period when scientific logic leads public health policy and programs. We can hope that extremist dogma will be placed where it belongs: on the fringe. But does that mean the problem is solved? For now, probably. But what about in the future? In America's future there will certainly be administrations in power that will attempt to influence public health practice in ways that may be contrary to the public's interest. And there is no way to prevent what happened with AIDS from happening again.

Last year I called for a new system to insulate public health from political interference.[3] Such a system should be viewed as advantageous to both public health practitioners and politicians alike. Public health practitioners need freedom to make sound policy decisions and execute public health programs even though these programs may not be politically popular; examples from AIDS prevention today, such as needle exchange, highschool sex/AIDS/drug education, and drug treatment, come readily to mind. For their part, politicians need to be freed from the burden of having to defend these politically charged issues. To place responsibility for prevention programs squarely with "the experts" could at least relieve legislators of some of the burden.

A major problem emerges in such a model, however, when political decision

**Editor's Note.** See related article by McQuillan et al. (p 747) in this issue.

makers must allocate resources. If public health is isolated from the political process, it will not be allocated the resources necessary to carry out these unpopular yet essential activities. One alternative is to guarantee public health budgets. Is it time for a gas tax equivalent for public health? Or perhaps this is the place for the Boards of Health. Independent yet respected boards could serve as the political instrument forging the political will. Once resources are identified, independent public health practitioners could execute these activities.

Two years ago, when I made the call for an insulating structure, the political climate was quite different. With the current administration, the call seems less urgent. I caution, however, against letting the issue drop. Who knows what is to come in the future? It seems wise to design and establish a system that shelters the technical functions of public health from politicians and, at the same time, protects politicians from some of the unavoidable political and social reactions from unpopular public health actions. Now, when logic can prevail, is the time to establish such a system, rather than waiting for a future time of chaos when it will be impossible. □

*Donald P. Francis*

The author is with Genentech Inc, South San Francisco, Calif.

Requests for reprints should be sent to Donald P. Francis, MD, DSc, Genentech Inc, 460 Point San Bruno Blvd, MS-59, South San Francisco, CA 94080.

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